

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1692

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL - Ellicott City</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL - Ellicott City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fairfield Farm</u>		STREET ADDRESS (If rural give location) <u>Fairfield Farm</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>George E. S. Bayless</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>February 10 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>agriculture</u>	8. DATE OF BIRTH <u>Aug. 23, 1891</u>
13. FATHER'S NAME <u>William H. Bayless</u>		9. AGE last birthday <u>59</u> yrs.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>	
16. SOCIAL SECURITY No.		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
17. INFORMANT <u>Geo. E. S. Bayless, Jr. Fairfield Farm Md.</u>		14. MOTHER'S MAIDEN NAME <u>Annie Silver</u>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
4201 Immediate cause (a) <u>Coronary Occlusion</u>	<u>10 Min.</u>
95b Antecedent cause(s) (b) <u>Arterio. sclerosis</u>	<u>5 years</u>
(c) <u>Hypertension, Rheumatic Heart</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan, 1921, to Feb. 10, 1951, that I last saw the deceased alive on Feb. 9, 1951, and that death occurred at 9 AM m., from the causes and on the date stated above.

SIGNATURE Wm. L. Ford - M.D. (Degree or title) ADDRESS 20 E. Preston St., Baltimore, Md. DATE SIGNED 2 - 12 - 51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>cremation</u>	<u>2 - 12 - 51</u>	<u>Loudon Park</u>	<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2/12/51</u>	<u>Wm. L. Ford</u>	<u>John O. Mitchell & Sons, Inc.</u>	<u>-1900 Eutaw Place Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1693

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH- COUNTY <u>Hannover</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>4 1/2 yrs</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Hannover</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Cora</u> (First) <u>A.</u> (Middle) <u>Blakemore</u> (Last)	4. DATE OF DEATH <u>Feb.</u> (Month) <u>19</u> (Day) <u>1957</u> (Year)		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u> 8. DATE OF BIRTH <u>October 23, 1868</u> 9. AGE last birthday <u>82</u> yrs. If under 1 year Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>		11. BIRTHPLACE (State or foreign country) <u>Kachland Virginia</u>	
13. FATHER'S NAME <u>Philip Stuckley</u>		14. MOTHER'S MAIDEN NAME <u>Nannetta Scroggins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <u>Miss H. Evelyn Rogers Savage, Md</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Myocardial Insuff.</u>					<u>6 wks.</u>
(b) Antecedent cause(s) <u>Rheumatoid Arthritis</u>					<u>5 yrs.</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Seirolity</u>					<u>5 yrs.</u>
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 4th 1949</u> , to <u>Feb. 19, 1951</u> , that I last saw the deceased alive on <u>Feb. 19, 1951</u> , and that death occurred at <u>6 P.</u> m., from the causes and on the date stated above.					
SIGNATURE <u>Shank Shingley, M.D.</u>		(Degree or title)		ADDRESS <u>Savage, Md.</u> DATE SIGNED <u>2/21/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/22/51</u>	NAME OF CEMETERY OR CREMATORY <u>Savage Cemetery</u>		LOCATION (City, town, or county) <u>Savage, Maryland</u> (State)	
DATE REC'D BY LOCAL REG. <u>2/21/51</u>	REGISTRAR'S SIGNATURE <u>Shank Shingley</u>		24. FUNERAL DIRECTOR <u>Dr. Will Davidson Laurel, Md</u>		ADDRESS



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 19.1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH - COUNTY <u>Howard</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>md</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Ellicott City</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>millers corner Montgomer Rd</u>		STREET ADDRESS (If rural, give location) <u>Miller on Montg Rd</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William Louis Braithling</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 12 1971</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept 25 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y. Shipyard</u>	11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa</u>
13. FATHER'S NAME <u>John Lee Braithling</u>		14. MOTHER'S MAIDEN NAME <u>Helena Hiller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. INFORMANT AND ADDRESS <u>Mr. Lee Braithling Ellicott City</u>	
16. SOCIAL SECURITY NO. <u>132-08-1971</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.2 Immediate cause (a) <u>Myocardial Infarct</u>		6 mo
131.8 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Chor. Myocarditis</u>		5 yrs
(c) <u>General arteriosclerosis</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension</u>		10 yrs
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1949, to Feb 7 1971, that I last saw the deceased alive on Feb 1 1971, and that death occurred at 7 30 m., from the causes and on the date stated above.

SIGNATURE Dr. B. Braithling (Degree or title) ADDRESS 3605 main st Ellicott City 23 md DATE SIGNED 2/12/71

23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>2-17-1971</u>	NAME OF CEMETERY OR CREMATORY <u>NORTH CEDAR HILL</u>	LOCATION (City, town, or county) (State) <u>PHILADELPHIA, Pa 19137</u>
DATE REC'D BY LOCAL REG. <u>2-13-51</u>	REGISTRAR'S SIGNATURE <u>John B. Loughran, R.E.S.</u>	24. FUNERAL DIRECTOR <u>F.C. HIGLEY BOTHOM ELLICOTT CITY, Md.</u>	ADDRESS <u>(Miss) E. Ruth Williams, Local Registrar - 2-18-51</u>

RECEIVED
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH COUNTY Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Howard	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Colesville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Colesville, near Laurel	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) Laurel, R. F. D.	
3. NAME OF DECEASED (Type or Print) William		4. DATE OF DEATH (Month) Feb. (Day) 2 (Year) 1951	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Abt. 1860
9. AGE last birthday abt. 90 yrs.		10. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Howard Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Benjamin Cooper		14. MOTHER'S MAIDEN NAME Sofie Snell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Carrie Tibbs, Laurel RFD, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Cerebral Hemorrhage**

INTERVAL BETWEEN ONSET AND DEATH

1 day

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Hypertensive Cardio Vascular**

10 yrs.

(c) **Generalized Arteriosclerosis**

20 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Senility

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **2/30**, 19**48**, to **2/2**, 19**51**, that I last saw the deceased

alive on **12/29**, 19**50**, and that death occurred at **4:30 a.m.**, from the causes and on the date stated above.

SIGNATURE **J. M. Warren M.D.** (Degree or title)

ADDRESS

DATE SIGNED

Laurel, Maryland

2/4/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Feb. 5, 1951	NAME OF CEMETERY OR CREMATORY Shello Burial Ground	LOCATION (City, town, or county) Colesville, nr. Laurel, Md.
DATE REC'D BY LOCAL REG. 2/5/51	REGISTRAR'S SIGNATURE Frank W. Shipely	24. FUNERAL DIRECTOR Ridgley Selby	ADDRESS 401 Wash. ave 970246 Laurel Md

MARGIN RESERVED FOR BINDING

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VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1606

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hanover, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hanover Rd</u>		STREET ADDRESS (If rural give location) <u>Hanover, Rd</u>	
3. NAME OF DECEASED (First) <u>TERESA</u>	(Middle) <u>MARY</u>	(Last) <u>DiLerge</u>	4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>21</u> (Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>28 NOV 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE last birthday <u>47</u> yrs. If under 1 year Months Days Hours Mln.
13. FATHER'S NAME <u>Louis C. DiLerge</u>		14. MOTHER'S MAIDEN NAME <u>TERESA SABELA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>216-30-5722</u>	
17. INFORMANT <u>Louis C. DiLerge</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>myocardial infarction, coronary</u>		<u>36 hrs.</u>
Antecedent cause(s) (b) <u>Septic Infection of lungs</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes mellitus?</u>		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NO</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>—</u>	(CITY OR TOWN) <u>—</u>	(COUNTY) <u>—</u>	(STATE) <u>—</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>—</u>		

22. I hereby certify that I attended the deceased from 19 Feb, 1951, to 21 Feb, 1951, that I last saw the deceased alive on 19 Feb, 1951, and that death occurred at 6:30 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) <u>George E. Gealean M.D.</u>	ADDRESS <u>Elkridge, Md</u>	DATE SIGNED <u>21 Feb 51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>2/24/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Augustine Cemetery</u>
DATE REC'D BY LOCAL REG. <u>2/23/51</u>	REGISTRAR'S SIGNATURE <u>A W Hedden</u>	LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u>
24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 St. Paul St</u>

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1697

1. PLACE OF DEATH - COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md.</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dorsey</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>William</u>	(Middle) <u>Herbert</u>	(Last) <u>Englehart</u>	4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>11</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 6, 1881</u>
9. AGE last birthday <u>69</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sheet Metal Worker, B. & O.R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Englehart</u>		14. MOTHER'S MAIDEN NAME <u>Frances Harman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY No. <u> </u>	
17. INFORMANT AND ADDRESS <u>Mrs. Lillian A. Englehart, Dorsey, Md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

443X
93d

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 17, 1951 to Feb. 11, 1951, that I last saw the deceasedalive on Feb. 11, 1951, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, or REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2/13/51Feb. 14/51Meadowridge Memorial Pk. Dorsey, Md.4101 Edmondson Ave.591506

MARGIN RESERVED FOR BINDING

VS. A15

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CERTIFICATE OF DEATH

1698
Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Willie</u> (Middle) <u>Irene</u> (Last) <u>Gardner</u>		(Month) <u>February</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Aug 22 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>72</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>A. C. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Parkins Randolphus Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Isabel Wesley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. B. L. Gardner, Jessup, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Paralysis agitans (Parkinson's Disease)</u>			<u>12 yrs.</u>
Antecedent cause(s) (b) <u>350x</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>87c</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>none</u>	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u> </u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1939, to Feb. 18th, 1951, that I last saw the deceased alive on Feb. 17th, 1951, and that death occurred at 4 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank Shipley, M.D., Surgeon, Md. ADDRESS 7/18/51

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	DATE <u>2/20/51</u>	NAME OF CEMETERY OR CREMATORY <u>Woodridge Mem. Ch. Bury</u>	LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>
DATE REC'D BY LOCAL REG. <u>2/20/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>W. J. Dickner & Sons, Baltimore</u>	ADDRESS <u> </u>

NT ✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1609 19.1

1. PLACE OF DEATH- COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PINECLINIC, ELLICOTT CITY</u>		STREET ADDRESS (If rural, give location) <u>9-E. Leland Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>WILBERT</u>	(Middle) <u>JOHN</u>	(Last) <u>HUBERT</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>DEC. 23, 1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	9. AGE last birthday <u>85</u> yrs. If under 1 year Months <u>2</u> Days <u>3</u> If under 24 hrs. Hours <u>3</u> Min.
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>GEORGE HUBERT - 9-E. Leland ST. Chevy Chase, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

334x Immediate cause (a) CEREBRAL ARTERIOSCLEROSIS AND DEGENERATION

97 Antecedent cause(s) (b) PSYCHOSIS DUE TO ARTERIOSCLEROSIS

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		INJURY			
HOMICIDE					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from NOV. 2, 1949, to FEB. 26, 1951, that I last saw the deceased alive on FEB. 25, 1951, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

SIGNATURE Living J. Taylor M.D. ADDRESS PINECLINIC DATE SIGNED FEB. 26, 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREON <u>Feb. 26/51</u>	NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>	LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
DATE REC'D BY LOCAL REG. <u>Feb. 26, 1951</u>	REGISTRAR'S SIGNATURE <u>John B. E. L.</u>	24. FUNERAL DIRECTOR <u>Thomas M. Hyson, Wash. D.C.</u> <u>Hyson's Funeral Home - 1300-N ST. N.W.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 1 1951
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1610

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Quilford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Quilford</u>	
TOWN <u>Quilford</u>		TOWN <u>Quilford</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Clarey Road</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Charles</u> (Middle) <u>William</u> (Last) <u>Jackson</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>11</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-25-1872</u>
9. AGE last birthday <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>William Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Jeannette White</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>1631-2-13-51</u>	
17. INFORMANT <u>Miss Dora M. Carter</u>		<u>Quilford, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Lobar Pneumonia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) _____

(c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 21, 1951, to Feb 11, 1951, that I last saw the deceased

alive on Feb 11, 1951, and that death occurred at 3 P.M., from the causes and on the date stated above.

SIGNATURE J. B. Bradbridge ADDRESS Elkridge Md DATE SIGNED 2-13-51

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF <u>2-15-1951</u>	NAME OF CEMETERY OR CREMATORY <u>First Baptist Church</u>	LOCATION (City, town, or county) <u>Quilford, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>2/15/51</u>	REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>	24. FUNERAL DIRECTOR <u>W. H. Hedrick</u> ADDRESS <u>1631 Druid Hill Ave.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

1611

Reg. Dist. No.

1. PLACE OF DEATH - COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glenwood</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 97 2 miles south of Route 40</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>2236 Madison Ave.</u>	
3. NAME OF DECEASED (First) <u>Ira</u> (Middle) <u>Oliver</u> (Last) <u>Johnson</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>17</u> (Year) <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>?</u>	8. DATE OF BIRTH <u>2-4-92</u>
9. AGE last birthday <u>59</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Hawaii Co. Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>Hawaii Co. Ind.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Emma Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>1918</u>		16. SOCIAL SECURITY NO. <u>215-14-4335</u>	
17. INFORMANT <u>James Johnson</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Fracture of Skull at base</u>		<u>instant</u>	
(b) Antecedent cause(s) <u>823.5</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>170c</u>			
(c) OTHER SIGNIFICANT CONDITIONS <u>170c</u> Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>street</u>	(CITY OR TOWN) <u>Glenwood</u> (COUNTY) <u>Howard</u> (STATE) <u>Ind</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2</u> <u>17</u> <u>51</u> <u>4:50 p.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Lost control of auto which ran off road into a tree</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>George E. Bunting M.D.</u> Deputy Medical Examiner for Howard County		DATE SIGNED <u>2-17-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Interred Feb 24th 1951</u>	DATE THEREOF <u>Feb 24th 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Arbutus M. Park</u>	LOCATION (City, town, or county) (State) <u>Hatfield Ind</u>
DATE REC'D BY LOCAL REG. <u>2/21/51</u>	REGISTRAR'S SIGNATURE <u>R. W. Reduck</u>	24. FUNERAL DIRECTOR <u>George T. G. Gibson Jr.</u>	ADDRESS <u>430646</u> <u>1735 David Hill Ave - 17</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

1612

Reg. Dist. No. 19.1

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> Rural HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bethany Lane</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> Rural STREET ADDRESS (If rural give location) <u>Bethany</u>	
3. NAME OF DECEASED (Type or Print) <u>Otis William Johnson</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>2-9-51</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-10-1888</u> 9. AGE last birthday <u>62</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Box Factory</u>	11. BIRTHPLACE (State or foreign country) <u>Howard Co. Md</u>
13. FATHER'S NAME <u>Henry Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary G. Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>213-14-9861</u>	
		17. INFORMANT <u>Hattie Johnson, Ellicott City, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Coronary Thrombosis</u>		<u>instant</u>
(b) Antecedent cause(s) <u>Diabetes Mellitus</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>2 year</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE George E. Buehler M.D. (Degree or title) ADDRESS Ellicott City, Md. DATE SIGNED 2-9-1951

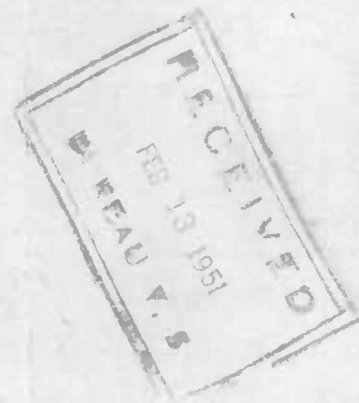
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2-12-1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Louis</u>	LOCATION (City, town, or county) (State) <u>Clarksville, Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb. 10, 1951</u>	REGISTRAR'S SIGNATURE <u>John B. Loughran Jr.</u>	24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u>	ADDRESS <u>Ellicott City, Md.</u>

B. E. L.

970457

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1613
Reg. Dist. No. 195

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Seagoville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Seagoville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Henry</u> (First) <u>Miles</u> (Middle) <u>Miles</u> (Last)		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Jan 12 1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	9. AGE last birthday <u>88</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>High Ridge, Howard Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Franklin Miles</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Willis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Harry Miles - Laurel, RFD No.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
450.0 Immediate cause (a) <u>Bronchopneumonia</u>			10d.
107 Antecedent cause(s) (b) <u>Generalized Atherosclerosis</u>			10yr.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Senility</u>			"
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Cystitis</u>			2yr.
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 6/29, 1939, to 2/7, 1951, that I last saw the deceased alive on 6/2, 1951, and that death occurred at 4:45 p.m. from the causes and on the date stated above.

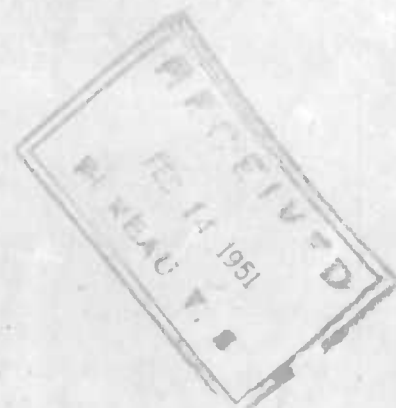
SIGNATURE <u>J. M. Barner</u>	(Degree or title)	ADDRESS <u>Laurel, Md.</u>	DATE SIGNED <u>2/7/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Feb. 10, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cemetery</u>	LOCATION (City, town, or county) <u>Seagoville, Howard</u> (State)
DATE REC'D BY LOCAL REG. <u>2/9/51</u>	REGISTRAR'S SIGNATURE <u>Shank Shipley</u>	24. FUNERAL DIRECTOR <u>Dr. W. B. Donaldson</u>	ADDRESS <u>Laurel, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

290116



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1614

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>	
TOWN <u>Elkridge</u>		TOWN <u>Elkridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6201 Wash Blvd</u>		STREET ADDRESS (If rural, give location) <u>6201 Wash Blvd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Rose</u>	(Middle) <u>Gertrude</u>	(Last) <u>Owens</u>
4. DATE OF DEATH	(Month) <u>Feb</u>	(Day) <u>4</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar 16, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	9. AGE last birthday <u>62</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Elkridge Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elijah Bush</u>		14. MOTHER'S MAIDEN NAME <u>Anna Bowers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Joseph L. Owens, 6201 Wash Blvd, Elkridge 27 Md</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute Coronary occlusion</u>			<u>1 hr</u>
Antecedent cause(s) (b) <u>Arteriosclerotic hypertension</u>			<u>3 yrs</u>
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>Pulmonary osteoma with cardiac failure</u>			<u>1 hr</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb 4 1951, to Feb 4 1951, that I last saw the deceased alive on Feb 4 1951, and that death occurred at 5 a.m., from the causes and on the date stated above.

SIGNATURE Dr. B. B. Burch (Degree or title) ADDRESS 5609 main St, Elkridge 27 Md DATE SIGNED Feb 4/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/7/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Augustine's Cem</u>	LOCATION (City, town, or county) <u>Elkridge Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>2/5/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Pedersen</u>	24. FUNERAL DIRECTOR <u>John J. Owens & Son</u>	ADDRESS <u>92 Collins St.</u>	

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

1615

Reg. Dist. No. 193

1. PLACE OF DEATH— COUNTY <u>Howard</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>LISBON</u> TOWN <u>LISBON</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>FREDERICK Rd. LISBON Md.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>Md.</u> COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>LISBON</u> TOWN <u>LISBON</u> STREET ADDRESS (If rural give location) <u>FREDERICK Road</u>	
3. NAME OF DECEASED (Type or Print) <u>JAMES</u> (First) <u>THOMAS</u> (Middle) <u>SIMMONS</u> (Last)		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>19</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8-19-1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEAMSTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUTCHER BUSINESS</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THOMAS WESLEY SIMMONS</u>		14. MOTHER'S MAIDEN NAME <u>RACHEL ANN HEAPS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-225902</u>	
17. INFORMANT <u>ROBERT E. SIMMONS</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause <u>422.1 Antecedent cause(s)</u> <u>93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>	(a) <u>Arteriosclerotic Cardio-Vascular Disease</u> (b) <u>2 years</u> (c)
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II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		(CITY OR TOWN) (COUNTY) (STATE)
HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

George E. Bunting M.D.
 DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY

ADDRESS

Ellicott City, Md.

DATE SIGNED

2-19-51

23. BURIAL, CREMATION (Specify) <u>BURIAL</u>	DATE THEREOF <u>2-22-1951</u>	NAME OF CEMETERY OR CREMATORY <u>WORTHING Park</u>	LOCATION (City, town, or county) <u>Baltimore Md.</u>
DATE REC'D BY LOCAL REG. <u>2-21-51</u>	REGISTRAR'S SIGNATURE <u>E. Paul Quinn</u>	24. FUNERAL DIRECTOR <u>L. M. Waltz, Winfield, Md.</u>	ADDRESS

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R. L. C. 1111 D
FEB 20 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

1615
 190

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Howard		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE TENN. COUNTY Sullivan	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Middle Patuxent River		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Kingsport	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) 1726 PARK ST.	
3. NAME OF DECEASED (Type or Print)	(First) SYLVIA	(Middle)	(Last) WELLS
4. DATE OF DEATH	(Month) February	(Day) 18	(Year) 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <input checked="" type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 36 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Drowning	
Antecedent cause(s) (b) Acute alcoholism	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office, etc.) INJURY River
(CITY OR TOWN) Middle Patuxent River	(COUNTY) Howard
(STATE) Md.	
TIME (Month) (Day) (Year) (Hour) OF INJURY Found 2/18/51 7:30P	INJURY OCCURRED While at work <input type="checkbox"/> Nnt while at work <input checked="" type="checkbox"/>
HOW DID INJURY OCCUR? Found drowned	

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒.

SIGNATURE **William Volz** (Degree or title) ADDRESS **700 Fleet St., Balto. 2, Md.** DATE SIGNED **Feb. 19, 1951**

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF	NAME OF CEMETERY OR CREMATORY Kingsport Cemetery	LOCATION (City, town, or county) Kingsport	(State) Tennessee
DATE REC'D BY LOCAL REG. 2/20/51	REGISTRAR'S SIGNATURE R. W. Hedrick	24. FUNERAL DIRECTOR Huff Funeral Home - Kingsport	ADDRESS vvvvvvv Tenn	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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2411 W. Charles St.